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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Jesus Herrera Lao, M.D.** **25431 Rue de Fleur** **Escondido, CA 92026** **Physician's and Surgeon's Certificate No. A 72729,** Respondent.	Case No. 800-2017-036151 **A C C U S A T I O N**

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 31, 2000, the Medical Board issued Physician's and Surgeon's Certificate No. A 72729 to Jesus Herrera Lao, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2021, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

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"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

7. Section 4021 of the Code states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

8. Section 4022 of the Code states:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

"...

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

9. Unprofessional conduct under Business and Professions Code section 2234 is conduct which breaches the rules or ethical code of the medical profession, or conduct which is

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unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine.[1]

DEFINITIONS

10. Morphine Milligram Equivalent (MME) or Morphine Equivalent Dosage (MED), as it was previously known, is a value assigned to opioids to represent their relative potencies. MME is determined by using an equivalency factor to calculate a dose of morphine that is equivalent to the ordered opioid. Daily MME (or MED) is the sum of the MME of all drugs in the opioid class a patient is likely to take over 24 hours, and that total is used to determine if the patient is nearing a potentially dangerous threshold. The primary side effect of opioid overdose is respiratory depression, which frequently leads to serious complications or death.

11. As an example of the use of daily MME/MED, the Centers for Medicare & Medicaid Services (CMS) publishes morphine equivalent tables. In its 2017 Call Letter draft, CMS recommends a point-of-sale (POS) "soft edit threshold" of 90-120 mg daily cumulative MME, which can be overridden by a pharmacist, and a "hard edit threshold" of 200 mg daily cumulative MME. A claim is rejected at the POS if the beneficiary's active or overlapping opioid prescriptions reach or exceed a certain daily cumulative MED threshold.

12. Methadone is a synthetic opioid prescribed for moderate to severe pain. It is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. It is used to treat pain and opiate addiction.

13. Oxycodone, also known as OxyContin or Roxicodone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. It is used to treat pain.

14. Morphine is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. It is used to treat pain.

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[1] *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.

15. Hydromorphone, also known as Dilaudid, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. It is used to treat pain.

16. Tapentadol, also known as Nucynta, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Code section 4022. It is used to treat pain.

17. Percocet and Roxicodone are brand names for oxycodone and acetaminophen, a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. It is used to treat pain.

18. Hydrocodone/acetaminophen (apap), also known as Norco, Vicodin and Lortab, is a Schedule III controlled substance as designated by Health and Safety Code section 11056(e), and is a dangerous drug as designated by Code section 4022. It is used to treat pain.

19. Temazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. It is used to treat insomnia and anxiety.

20. Clonazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Code section 4022. It is an anticonvulsant or antiepileptic drug, and also used to treat panic attacks.

21. Diazepam, also known as Valium, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms.

22. Carisoprodol, also known as Soma, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Code section 4022. It is used to treat muscle spasms.

23. Seroquel, a brand name for quetiapine, is a psychotropic medication used to treat schizophrenia. It is also used in the treatment of major depression and bipolar disorder, and is a dangerous drug pursuant to Code section 4022.

24. Buspar is a dangerous drug pursuant to Code section 4022. It is used to treat anxiety.

25. Amitriptyline hydrochloride, also known as Elavil, is a tricyclic antidepressant with analgesic properties, widely used to treat depression and neuropathic pain. It is a dangerous drug pursuant to section 4022.

26. Tizanidine, also known as Zanaflex, is a short-acting muscle relaxer. It is a dangerous drug pursuant to Code section 4022.

27. Baclofen is a muscle relaxer and an antispasmodic agent. It is a dangerous drug pursuant to Business and Professions Code section 4022.

28. Venlafaxine is a dangerous drug pursuant to Business and Professions Code section 4022. It is used to treat major depressive disorder, anxiety, and panic disorder.

29. Lasix is a dangerous drug pursuant to Code section 4022. It is used to treat fluid retention in people with congestive heart failure, and other health conditions.

30. Atorvastatin, also known as Lipitor, is a statin medication used to prevent cardiovascular disease in those at high risk and treat abnormal lipid levels. It is a dangerous drug pursuant to Business and Professions Code section 4022.

31. Gabapentin is a nerve pain medication and anticonvulsant. It acts as a sedative, and is a dangerous drug pursuant to Business and Professions Code section 4022.

32. A Lidoderm patch contains 5% lidocaine and is a local anesthetic. This strength is available by prescription only, although a 3.6% version is available over-the-counter.

33. Ibuprofen is a medication in the nonsteroidal anti-inflammatory drug (NSAID) class that is used for treating pain, fever, and inflammation. It can be purchased over-the-counter in 200 milligram (mg) tablets, while higher doses require a prescription.

34. CURES is a prescription drug monitoring program that includes information regarding prescriptions for certain controlled substances. (Health & Saf. Code, § 11165, subds. (a) & (d); *Lewis v. Superior Court* (2017) 3 Cal.5th 561, 565.)

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FACTUAL ALLEGATIONS

35. At all times mentioned herein, Respondent was a board-certified specialist in physical medicine and rehabilitation.

36. The standard of care requires that a physician who is prescribing controlled substances to treat a patient with pain see the patient periodically in order to monitor the therapy. This allows the physician to assess the patient's progress toward treatment objectives, to assess the patient's adherence to treatment with controlled substances, and to assess whether the patient is having any adverse effects from the controlled substances. This periodic review enables the physician to determine whether treatment of the patient's pain with controlled substances should be continued or modified.

37. The standard of care also requires that a patient's vital signs be checked, especially at the initial visit.

38. When prescribing opioids to a patient with asthma, the standard of care requires that the physician listen to the patient's lungs.

39. The standard of care requires that a physician keep adequate and accurate records of his treatment of a patient, including documentation of history and examination, diagnostic testing (if available), diagnoses or impressions, and a treatment plan. When treating pain, the physician should describe the pain in regard to its location, intensity, and impact upon functioning. There should also be a focused physical examination pertaining to the specific pain complaint.

Patient 1:

40. Patient 1, a male patient born in June 1962, was referred to Respondent's pain medicine practice for evaluation and treatment of lumbar stenosis and chronic pain syndrome. At the time of his referral, he was already taking high dose opioid analgesic medication. Respondent treated Patient 1[2] from on or about December 4, 2012, through August 2013.

41. At his first visit, on or about December 4, 2012, Respondent examined the patient and completed an eight-page template consultative report with handwritten entries in which he

[2] All patients mentioned herein are referred to by number, rather than by name or initials, to protect their privacy. The true identity of the each of the patients is known to all the parties.

described the nature and extent of Patient 1's pain and made reference to prior treatments, including a laminectomy in 2010. Respondent listed the pain medicines which Patient 1 was then taking, including methadone 10 mg, gabapentin 600 mg and oxycodone 15 mg, but the frequency of the dosage is not clear from the notes. Respondent also listed Lasix and Lipitor as then current medications, without indicating either dose or frequency. His treatment plan is not stated in this office note, with no reference to medications he prescribed at this visit.

42. Patient 1 completed a Comprehensive Pain Management Questionnaire around the time of his first visit. In response to a question on the questionnaire, Patient 1 disclosed that he had been treated by a psychiatrist or had been in psychotherapy in 2011, and reported feeling sad or depressed, sleeping only one to three hours per night. Patient 1 omitted the question concerning whether he had thoughts of suicide. There is no indication in the record that Respondent explored these symptoms with Patient 1.

43. Patient 1's past medical history included coronary artery disease, morbid obesity, hypertension, hyperlipidemia, low back surgery, gastric bypass procedure, coronary artery bypass grafting, and placement of a pacemaker defibrillator. Respondent diagnosed Patient 1 with lumbago and prescribed methadone 20 mg three times a day, and 30 mg oxycodone four times per day.

44. Respondent's treatment goals or objectives for Patient 1 is unclear from his records dated on or about this visit, mentioning only that he was increasing the patient's previous 15 mg oxycodone to 30 mg "for better pain control."

45. Patient 1 suffered from high blood pressure, heart disease, and morbid obesity. Respondent did not check his vital signs at any time during his treatment of Patient 1.

46. After the initial visit, Respondent saw Patient 1 for a further seven (7) visits. Respondent's notes for these visits consist of two-page template reports upon which he made handwritten entries. The office note for each of these visits indicate the patient had "fair pain control" without further explanation. The physical exam for every note states "L3, L5 tender to palpation" (in abbreviated form). Respondent's notes for May, June, and August 2013, have an additional line, "morbidly obese."

47. Respondent's treatment goals for Patient 1, relative to the prescribed medications, are unclear, and Respondent's notes do not indicate whether his treatment goals, if any, were being met. The dosages of the medicines are not clearly specified, and when there are changes in the medications, the rationale for the changes is not documented.

48. One example of Respondent's unclear prescribing practices is that, on or about April 24, 2013, Respondent changed Patient 1's prescription for oxycodone to morphine. No explanation for the change can be found in Respondent's notes for this visit.

49. Another example is Respondent's prescribing of amitriptyline (Elavil). Adverse effects of amitriptyline include lightheadedness and cardiac conduction problems, among others. Patient 1, at the age of 50 with a known history of heart disease, was at increased risk for adverse cardiac effects from amitriptyline. In addition, Patient 1's morbid obesity, in combination with his use of the sedative drug amitriptyline, placed him at significant risk for sleep apnea with its increased risk for cardiovascular morbidity and mortality.

50. Respondent first prescribed amitriptyline at a dose of 25 mg at bedtime, later increased to 75 mg at bedtime and, finally, on or about August 13, 2013, increased to 150 mg at bedtime. It is unclear from Respondent's notes both why he prescribed Patient 1 amitriptyline, and why he increased the dose. The medical record also does not show that Respondent talked with Patient 1 about potential adverse effects. Similarly, the medical record gives no indication that Respondent checked an electrocardiogram for Patient 1. At an interview conducted during the investigation of this case ("a subject interview"[3]), Respondent admitted that he did not discuss his prescribing of 150 mg of amitriptyline per day (in conjunction with 60 mg methadone per day) with Patient 1's cardiologist at the time of prescribing it.

51. Almost throughout the period of his treatment of Patient 1, including at the time of his last visit with Respondent on or about August 13, 2013, Respondent prescribed medication that equates to a MME of 780 mg daily.

[3] During the course of the investigation of this matter, Respondent attended three subject interviews to discuss his care and treatment of the seven patients mentioned in this Accusation. For convenience, these interviews are not identified by individual date, but generically referred to as "a subject interview."

52. Throughout his period of treatment of Patient 1, Respondent did not order any laboratory testing or urine drug screens of the patient.

53. There is no documentation concerning whether Patient 1 was taking his medications as directed or having problems controlling his use of the drugs.

54. Patient 1 passed away on August 24, 2013. The coroner's report attributed his death to heroin,[4] methadone and oxycodone effect with other significant conditions contributing to death, including morbid obesity, atherosclerotic heart disease, hypertensive heart disease, and pulmonary thromboembolism from deep venous thrombosis.

55. After Patient 1's passing, information came to light which suggests that Patient 1 may have suffered from sleep apnea and symptoms of depression, and consumed a high level of alcohol on a daily basis. It appears from Patient 1's medical record that Respondent was not aware of these potential risk factors.

Patient 2:

56. Patient 2, a female patient born in March 1958, was referred to Respondent's pain medicine practice in or around 2013 for evaluation and treatment of chronic low back and right leg pain dating back to 1999. At the time of her referral, she was already taking high dose opioid analgesic medication. Respondent treated Patient 2 from on or about October 22, 2013, through on or about January 14, 2015.

57. Respondent's initial note, for Patient 2's first visit with Respondent, on or about October 22, 2013, is a handwritten, template, eight-page report entitled History and Physical Pain Management. In it, he documented the history, physical examination, assessment, and plan. The note documents the dosage and frequency of medications Patient 2 was then taking, without specifying dosage and frequency.

58. At Patient 2's first visit, Respondent diagnosed her with failed back syndrome, and prescribed OxyContin 80 mg x 3 tablets per day, oxycodone 15 mg x 4 mg per day, and tizanidine

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[4]Patient 1's wife disputes any suggestion that Patient 1 used heroin, and there is no known evidence to the contrary.

6 mg x 4 tablets per day. Respondent's treatment plan for Patient 2 is unclear from his notes, as he did not explicate treatment objectives.

59. After the initial visit, Respondent saw Patient 2 for sixteen (16) follow-up visits between on or about November 19, 2013, and January 14, 2015. His office notes for these visits consist of two-page preprinted templates with handwritten entries, which are almost identical from visit to visit, with little or no variation, and do not assist in determining treatment goals.

60. Respondent's notes for Patient 2 provide no indication that he was monitoring the nature and intensity of Patient 2's pain, her response to treatment with the pain medicines, or her activity tolerance in relation to the medications.

61. There is no indication in Respondent's notes for Patient 2 that he was monitoring her for adverse effects from the drugs she was prescribed.

62. Respondent's notes make no mention of whether Patient 2 was taking her medications as directed or having problems controlling her use of the drugs.[5]

63. Respondent never checked the blood pressure and pulse of Patient 2, who had hypertension and was taking Diovan, an antihypertensive. Respondent's notes for Patient 2 contain scant documentation of his physical examination findings.

64. The dosages of the pain medicines prescribed by Respondent to Patient 2 are not clearly specified in his notes, and when there are changes in the medications, the rationale for the changes is not documented. For instance, at Patient 2's initial visit, Respondent reduced her then oxycodone dose by 15 mg daily, to 4 x 15 mg tablets per day. Two visits later, on or about December 17, 2013, he doubled it to 4 x 30 mg tablets per day, with no rationale provided for the increase. Respondent made no further changes to the dosages of Patient 2's opioid analgesics during the course of his treatment of her.

65. On or about January 14, 2015, at Patient 2's final visit with Respondent, he increased her tizanidine dose from 4 x 6mg tablets, to 6 x 6 mg tablets, but it is unclear from the records why he did so.

[5] The record contains one urine drug screen and two CURES reports that Respondent accessed during the time he treated Patient 2.

66. At the same time that Respondent was prescribing high dose opioid analgesic therapy plus tizanidine to Patient 2, he was aware that she was also being prescribed two benzodiazepines (temazepam and clonazepam) by her psychiatrist. There is no indication in the record that he collaborated his care of Patient 2 with the psychiatrist.

Patient 3:

67. Respondent treated Patient 3, a female born in November 1964, for a three-year period from on or about February 1, 2012[6] through on or about March 25, 2015, for chronic neck, low back, and knee pain. She had comorbid conditions including morbid obesity, osteoarthritis, hypertension, and major depression. Besides the aforementioned conditions, Respondent's notes for Patient 3 also reference her peptic ulcer disease.

68. Respondent's office visit notes consist of two-page preprinted templates upon which Respondent made handwritten entries. His treatment objectives are unclear from the medical record.

69. Respondent's initial diagnoses for Patient 3 at her first visit, on or about February 1, 2012, were lumbago, lumbar spondylosis, and morbid obesity. His notes on his physical examination of Patient 3 state, "morbidly obese; decreased lumbar sacral range of motions; L3 to L5, tender to palpation" (in abbreviated form). These physical examination notes of Patient 3 remain unchanged for the following four (4) visits.

70. At Patient 3's first visit, Respondent prescribed her Valium, morphine sulphate 60 mg (2 tablets, 3 x per day) and morphine sulphate 30 mg (1 tablet, 3 x per day) (an approximate total of 450 mg morphine sulfate per day), and hydromorphone 4 mg x 300 (roughly 40 mg per day).

71. On or about August 31, 2012, Respondent added cervicalgia and bilateral "knee DD"[7] to his assessment and plan, and added "decreased bilateral knee range of motion" and "C3, C6 tender to touch" to the physical examination note. This physical examination note remained unchanged at all Patient 3's future visits until on or about June 27, 2014.

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[6] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

[7] Possibly degenerative disease.

72. From on or about June 27, 2014, until September 26, 2014, Respondent's physical examination note for Patient 3 states only "morbidly obese."

73. Patient 3's pain was given a numerical rating in Respondent's treatment notes for February 1, 2012, February 29, 2012, March 28, 2012, April 11, 2012, and June 20, 2012. There is not another reference to pain intensity until April 26, 2013, when Respondent noted "poor pain control" in his notes for that visit. In the notes that follow, Respondent uses the terms "fair," "fair-poor," or "poor" pain control, without further elaboration.

74. In his note for Patient 3's visit on or about December 5, 2014, Respondent states the chief complaint is "severe knee pain and back pain and neck pain." This note also states that Patient 3 had "difficulty of walking and function," which is the only reference to Patient 3's activity tolerance, or the impact of the pain on her functioning, in his notes covering the approximately twenty-six (26) visits over the roughly three year period of his treatment of Patient 3.

75. Respondent maintained Patient 3 on his initial prescriptions of 40 mg of hydromorphone per day, and 450 mg of morphine sulfate per day throughout 2012, 2013, and 2014 through October 2014 (covering a total of thirty-one (31) visits).

76. On or about October 24, 2014, Respondent discontinued all the morphine and the Dilaudid. In their place, he prescribed 40 mg methadone per day and Nucynta IR 100 mg respectively. No explanation for the change in medications is provided in Respondent's note for this visit. Respondent made the change without doing any type of morphine equivalent dosing to determine how much Nucynta was necessary to substitute for the Dilaudid.

77. Approximately four (4) days later, on or about October 28, 2014, Patient 3 contacted Respondent's office, complaining of withdrawal symptoms including diarrhea, sweats, chills, cramping, and nausea. On that date, Respondent prescribed two (2) clonidine 0.3 mg transdermal patches (one (1) patch per seven days) for Patient 3, as well as Phenergan 25 mg, four (4) x per day. On or about November 3, 2014, Patient 3 again called in with complaints that the medications were not working for her. She was advised to return to the clinic for medication adjustment.

78. On or about November 7, 2014, Patient 3 returned to the clinic. No mention is made of her withdrawal symptoms. At this visit, Respondent discontinued the methadone 40 mg per day, changed the Nucynta IR 100 mg to Nucynta ER 250 mg (two (2) tablets a day), and added oxycodone 15 mg four (4) times per day. On or about November 26, 2014, Respondent discontinued the oxycodone and started morphine IR. On or about December 5, 2014, the Nucynta ER was increased to three (3) tablets per day, the morphine IR was discontinued, and Patient 3 was prescribed Dilaudid once more (24 mg per day). Respondent's notes provide no explanation for or rationale behind the changes.

79. It is generally unclear from his notes what Respondent was prescribing Patient 3, or why. In addition to prescribing her high dose opioid analgesic medicine, at other times he appears to have also prescribed her diazepam, baclofen, and venlafaxine.

80. Respondent's notes for his treatment of Patient 3 do not reflect that he was monitoring her for adverse effects from the medications she was taking. For instance, there is no indication that any laboratory tests were ever performed to check Patient 3's renal or liver functions. Respondent also never took Patient 3's vital signs, despite her suffering from hypertension and being morbidly obese (with a reported weight of 350 pounds). After Patient 3's first three (3) office visits, her actual weight is never again mentioned in Respondent's notes.

81. Respondent's notes of his musculoskeletal and neurological examinations of Patient 3 contain scant documentation of his examination findings. In his note dated October 24, 2014, he noted that Patient 3 had recently fallen; however, no further details are provided either in terms of history or his physical examination of Patient 3.

Patient 4:

82. Respondent treated Patient 4, a female born in November 1962, from on or about February 8, 2012 through on or about July 24, 2013.

83. Patient 4 complained of low back pain that had begun after an accident in July 1992. She reported taking oxycodone and gabapentin since 2004, and ibuprofen and carisoprodol since 2005. She further reported having had three surgeries and indicated a history of high blood pressure.

84. Respondent first saw Patient 4 on or about February 8, 2012. His note for this visit is an eight-page, handwritten, template consultative report, in which he described the nature and extent of Patient 4's pain and made brief reference to prior treatments, including three lumbar surgeries, the nature and extent of which are unclear. Respondent listed Patient 4's pain medicines as OxyContin, oxycodone, Soma, Motrin, and gabapentin. Patient 4's past medical history was notable for a right kidney stone.

85. Respondent diagnosed Patient 4 with failed back syndrome, and his treatment plan was pharmacotherapy. He refilled her medications including OxyContin 480 mg daily, Percocet 10/325mg x 4 tablets daily, gabapentin 1200 mg daily, amitriptyline 50 mg daily, Soma four tablets daily, and ibuprofen 800 mg four tablets daily.

86. After the initial visit, Respondent's office notes for Patient 4 are two-page, template reports upon which he made handwritten entries.

87. Respondent's treatment objectives are unclear from his chart on Patient 4.[8]

88. Over the course of sixteen (16) office visits, Respondent noted a numerical pain intensity rating for Patient 4's pain on the first three visits only. A further five (5) visits, starting in July 2012, state "fair pain control" without elaboration, and the remaining visits are silent on Patient 4's pain intensity. There is no mention in Respondent's notes of Patient 4's activity tolerance, or the impact of her pain on her functioning. The chart contains no mention of whether Patient 4 was suffering from any adverse effects of the medications she was taking.

89. It is not apparent from Respondent's chart that he was making periodic review of Patient 4's progress, and adjusting the dosages of her pain medicines accordingly. Respondent maintained Patient 4 on the same dosage of OxyContin and oxycodone throughout 2012. On or about May 29, 2013, he indicated in his notes for that visit that Patient 4 would henceforth be on a reduced dose of four (4) OxyContin tablets per day, down from six (6) tablets per day. In reality,

[8] One exception to this is an undated, one-page pre-printed questionnaire required by the Inland Empire Health plan (IEHP), in which the Respondent answered questions, briefly indicating Patient 4's then pain rating, the pain scale goal, whether she was experiencing any side effects from her current pain reliever(s), and whether Patient 4 was exhibiting any aberrant drug-related behavior. When asked for his treatment plan, Respondent checked the box marked "continue present regimen," and added "[patient] stable on meds."

Respondent continued prescribing six (6) tablets per day. At a subject interview, Respondent stated that Patient 4 refused to reduce her dosage, and so the office note was only to reflect that he wanted her to go down to four (4) per day.

90. Respondent's chart for Patient 4 contains no reference to laboratory testing of her renal or liver functions. He also never checked Patient 4's blood pressure or pulse, despite her history of hypertension. Respondent's notes of his musculoskeletal and neurological examinations of Patient 4 contain the same cursory exam notes at every visit. No urine drug screen was performed until Patient 4's final visit on or about July 24, 2013, when the patient was discharged due to obtaining medications from other physicians.

Patient 5:

91. Respondent treated Patient 5, a male born in June 1976, for several years, including the period reviewed here, namely, from on or about January 19, 2011, through December 5, 2014. Respondent diagnosed Patient 5 with chronic low back and leg pain, and his notes also reflect the comorbid conditions of anxiety and migraine.

92. On or about January 19, 2011, Respondent saw Patient 5 and continued his prescriptions for morphine 100 mg ER (600 mg per day), and Roxicodone 45 mg per day. On or about June 7, 2011, Respondent doubled the Roxicodone prescription to 90 mg per day and, on or about January 3, 2012, increased the Roxicodone prescription to 120 mg per day. The increased dosage is not mentioned in Respondent's note for January 3, 2012, and no rationale or explanation is provided for either of the increased dosages.

93. After the initial visit, Respondent's office notes for Patient 4 are two-page, template reports upon which he made handwritten entries.

94. Respondent saw Patient 5 again, on or about November 30, 2012, and continued the prescription for 600 mg of morphine sulfate per day, while increasing the Roxicodone to 150 mg per day. No explanation for the increase can be found in his notes for this visit.

95. Respondent saw Patient 5 at twelve (12) visits during 2013, and ten (10) visits during 2014. During this period, he maintained the patient on 600 mg extended release morphine and

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150 mg Roxicodone per day. These medications, combined, add up to a morphine equivalent dosage of 825 mg daily.

96. Respondent's treatment objectives are unclear from the medical record. From November 2012 through February 2013, Respondent makes no attempt to describe Patient 5's pain. From March 2013 through August 2014, Respondent notes either "good" or "fair" pain control, without further elaboration. Between August 2014 and December 2014, there is again no description of the nature and extent of Patient 5's pain. Neither Patient 5's activity tolerance nor the impact of his pain on his functioning are addressed anywhere in Respondent's records.

97. It is unclear from the record whether Respondent was monitoring Patient 5 for adverse effects from the drugs he was prescribing him. Respondent never took Patient 5's vital signs, and his musculoskeletal and neurological examinations throughout the period under review contain nothing more than a cryptic, virtually identical, repeated reference to tenderness in the L3-L5 region. It is not stated whether this tenderness is bilateral, or more on one side than the other.

98. There are no imaging studies in Patient 5's file, and no results of any laboratory testing of Patient 5's renal or liver functions.

99. The medical record contains no comment on Patient 5's migraine, or how that may or may not have been impacted by his taking high-dose opioid analgesics.

100. Patient 5 was receiving concurrent prescriptions for clonazepam 2 mg daily, during 2013, written by another provider, possibly Patient 5's psychiatrist. Respondent never asked Patient 5 if he was consulting a mental health care provider and never conferred with any psychiatrist in order to collaborate in terms of Patient 5's treatment.

Patient 6:

101. Patient 6, a male born in November 1974, was a patient of Respondent's for several years including the period reviewed here, namely, from on or about August 5, 2011, through on or about May 22, 2014. Respondent treated Patient 6 for chronic low back and ankle pain, and his record for Patient 6 indicates the patient had undergone surgery for left ankle fracture at some point prior to August 5, 2011. The chart does not provide the date of the surgery.

102. Respondent's office notes for Patient 6 consist of two-page preprinted templates upon which Respondent made succinct handwritten entries. The records offer sparse information about Patient 6's pain complaints, response to treatment, Respondent's examination findings and treatment goals.

103. On or about August 5, 2011, Respondent saw Patient 6 and completed an office note for the visit. Under the typed heading, "Physical Exam," Respondent wrote (in abbreviated form) "bilateral ankle tenderness" and "L3, L5 tender to palpations."

104. At the visit on or about August 5, 2011, Respondent issued two prescriptions for OxyContin 80 mg (240 mg – 480 mg daily), one for 180 tablets to be mailed, and another for 18 tablets to be filled at a local pharmacy.

105. Respondent saw Patient 6 monthly from August 2011 through April 2012. In his notes for each of these visits, his physical exam findings were described almost identically as on August 5, 2011. They repeat Patient 6's tenderness of his ankle and in the lower lumbar paraspinal regions, without mention of whether bilateral or otherwise, and without range of motion measures. There is no neurological examination of the lower limbs. Throughout this period, Patient 6 was maintained on the same OxyContin dose of up to 480 mg per day, and, on each occasion, two OxyContin 80 mg prescriptions were issued, 180 to be mailed, and 18 to be filled locally.

106. On or about July 17, 2012, Respondent's notes on his physical exam of Patient 6 state only "L3, L5 tender to palpation." No mention is made of the nature or extent of Patient 6's pain (other than "LBP" under the heading "Interval Note"). The OxyContin prescriptions were again reissued.

107. Respondent's notes for Patient 6's office visits for twelve (12) of the first thirteen (13) visits in the period under review, indicate that the patient had either "fair" or "good" pain control, without elaboration. There is no mention anywhere in Respondent's notes for Patient 6 (for the entire period under review) of his activity tolerance or the impact of the pain on his functioning.

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108. Respondent's notes for Patient 6's office visits on or about December 31, 2013, January 28, 2014, February 25, 2014, and March 27, 2014, respectively, provide no information regarding any physical examination of Patient 6. The notes, likewise, are silent on the pain reported by Patient 6 (other than "LBP" under the heading "Interval Note"). At each of these visits, Respondent issued a prescription for OxyContin 80 mg, six (6) daily.

109. On or about April 8, 2013, a urine drug screen was performed on Patient 6, which showed a positive result for morphine, which Respondent was not prescribing to him. A positive test for morphine could result from taking morphine, codeine, or heroin. Respondent did not address this positive result for morphine with Patient 6 at any stage.

110. Patient 6's medical chart includes a note dated July 11, 2013, when the pharmacy called to say that, with all the extra prescriptions Patient 6 had been receiving, he should be approximately one and a half months ahead with his pills.

111. On or about July 31, 2013, Respondent again saw Patient 6. His physical exam is noted, again, as "positive L3, L5 tender to palpation." No mention is made of the July 11, 2013, call from the pharmacy, but, at this visit, Respondent issued only one OxyContin 80 mg prescription, for 180 tablets (six (6) daily).

112. No vital signs are recorded in any of Respondent's notes of Patient 6's visits.

113. The medical record for Patient 6 does not contain any outside medical reports or imaging studies.

114. Respondent's treatment objectives are unclear from the medical record. He prescribed 480 mg of OxyContin daily throughout his treatment of Patient 6 without making any effort to wean the patient's opioid, at least until June 2014.

115. In June 2014, due to insurance difficulties, Respondent attempted to substitute the 480 mg of OxyContin with 260 mg of morphine daily; however, the patient refused, and the change was not made. The proposed change would have resulted in a decrease from a MED of 720 mg daily, to 260 mg daily. This would likely have precipitated opioid withdrawal symptoms in Patient 6.

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116. Respondent prescribed OxyContin 80 mg as "one to two" tablets to be taken, three times a day. This effectively gave Patient 6 the latitude of varying his dosage by as much as 50% from day-to-day, and could led to significant fluctuations in the dose from day-to-day and precipitate symptoms of withdrawal or overmedication.

117. Respondent's chart for Patient 6 contains no discussion of possible side effects of the OxyContin, nor any indication that Respondent was monitoring the patient for any side effects, including constipation.

118. There are no laboratory results for renal or liver function tests in Patient 6's chart.

Patient 7:

119. Patient 7, a female born in September 1959, was a patient of Respondent from on or about June 14, 2013, through on or about December 27, 2013.

120. At Patient 7's initial visit on or about June 14, 2013, she completed a health history questionnaire, in which she identified herself as having chronic pain, multiple sclerosis and asthma. She reported previously experiencing asthma attacks and palpitations, and listed the many medicines she was taking, including Seroquel, Klonopin, Buspar, lorazepam, Benadryl, Meloxicam, and an albuterol inhaler.

121. Respondent examined Patient 7 on or about June 14, 2013, and documented his findings in a handwritten, eight-page template History and Physical note. In this note, among other things, Respondent documented the medications Patient 7 was then taking, but did not delineate their dosage and frequency. Respondent diagnosed lumbago, for which he prescribed physical therapy, lumbar x-rays, and medications, namely, hydrocodone/acetaminophen 10/325 mg four (4) tablets daily, and Robaxin 750 mg four times daily.

122. On his note for Patient 7's visit on or about June 14, 2013, Respondent remarked that her upper extremities exam showed sensation as being normal. Patient 7 had reported on her health history questionnaire that she experienced numbness in her hands due to multiple sclerosis.

123. At her visit on June 14, 2013, Respondent also prescribed Patient 7 Lidoderm 5% patches x 30, and carisoprodol 350 mg tablets x 120. These are not reflected in his notes.

124. Respondent did not see Patient 7 again until on or about December 27, 2013.

125. On or about October 23, 2013, in response to a telephone request from Patient 7, Respondent authorized another hydrocodone/acetaminophen 10/325 mg prescription for fifty-six (56) tablets.

126. Respondent did not check a urine drug screen during his treatment of Patient 7.

127. Patient 7 was on a complicated regimen of medications, including those prescribed by her primary care physician and Respondent. These included hydrocodone, carisoprodol, clonazepam, and Seroquel. These drugs in combination increase a person's risk for adverse effects, including excessive drowsiness, falls, fractures, impaired breathing, and unintentional overdose. Respondent did not collaborate with Patient 7's primary care physician in regards to her treatment and prescriptions.

128. There is no indication in the record that Respondent discussed with Patient 7 the risks of taking an over-the-counter medication with potential sedative effects when combined with other sedatives, like hydrocodone, Soma, clonazepam, and Seroquel.

129. Patient 7 was morbidly obese at 6 foot tall, weighing approximately 308 pounds. Respondent did not check her vital signs at either Patient 7's first or second visit.

130. Patient 7's history of asthma increased her risk for harm stemming from her use of controlled substances. At a subject interview, Respondent stated that he was not sure whether or not he had listened to Patient 7's lungs. Asthma is not listed under "past medical history" on either of Respondent's notes for Patient 7.

131. On or about December 27, 2013, Respondent saw Patient 7 again. Respondent's note for this visit is a two-page, template report on which he made handwritten entries. There is no discussion in the note of why Patient 7 had not returned for a follow-up visit in the previous six months.

132. Respondent's office note for Patient 7's visit in December 2013 indicates that he again prescribed hydrocodone/acetaminophen 10/325 mg; however, the frequency is not indicated. Also on this note, Respondent states under "physical exam," "L3 to L5, tender to palpation" (in abbreviated form). The record does not indicate whether this tenderness is bilaterally or otherwise. There is no documentation relative to treatment goals, and no

documentation concerning potential side effects from the medications Respondent prescribed to Patient 7.

133. Patient 7 passed away on December 28, 2013, and the autopsy report listed her cause of death as "acute hydrocodone intoxication" with contribution from hypertensive cardiovascular disease.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

134. Respondent Jesus Herrera Lao, M.D., is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, 4, 5, 6, and 7, as more particularly alleged hereinafter:

135. Paragraphs 35 through 133, above, are hereby realleged and incorporated by this reference as if fully set forth.

136. Respondent committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, 4, 5, 6, and 7, which included, but are not limited to:

(a) In regard to each patient, individually, Respondent failed to adequately monitor the patient's treatment with controlled substances; and/or

(b) In regard to each patient, individually, Respondent failed to maintain adequate and accurate records of his care and treatment of the patient.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

137. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records relating to the provision of services to Patients 1, 2, 3, 4, 5, 6, and 7, as more particularly described in paragraphs 35 through 133, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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THIRD CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

138. Respondent is further subject to disciplinary action under sections 2227 and 2234 of the Code, in that he has engaged in conduct which breaches the rules or ethical code of the medical profession, or conduct that is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. The circumstances are set forth in paragraphs 35 through 137, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 72729, issued to Respondent Jesus Herrera Lao, M.D.;

2. Revoking, suspending or denying approval of Respondent Jesus Herrera Lao, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Jesus Herrera Lao, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED:
June 20, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant